		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0022871

Facility Name: WEST CHICAGO TERRACE

Address: 928 JOLIET ROAD (Number) WEST CHICAGO (City) 60185 (Zip Code)

County: DUPAGE

Telephone Number: (847) 674-5795 **Fax #** (847) 674-5794

IDPA ID Number: 36-2883297

Date of Initial License for Current Owners: 10/01/76

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) MORRIS ESFORMES
(Title) GENERAL PARTNER

Paid Preparer
(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	120	Intermediate (ICF)	120	43,800	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	38,306	3,402		41,708	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,306	3,402		41,708	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.22%

D. How many bed-hold days during this year were paid by Public Aid?
932 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/76

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	139,597	8,843	5,940	154,380		154,380		154,380			1
2	Food Purchase		148,776		148,776		148,776	(600)	148,176			2
3	Housekeeping	99,846	12,804		112,650		112,650		112,650			3
4	Laundry	32,677	14,259		46,936		46,936		46,936			4
5	Heat and Other Utilities			56,059	56,059		56,059	268	56,327			5
6	Maintenance	53,853	1,518	35,150	90,521		90,521	2,931	93,452			6
7	Other (specify):*			6,633	6,633		6,633	81	6,714			7
8	**TOTAL General Services**	325,973	186,200	103,782	615,955		615,955	2,680	618,635			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	973,968	28,482	13,912	1,016,362		1,016,362		1,016,362			10
10a	Therapy	22,611		6,743	29,354		29,354		29,354			10a
11	Activities	69,511	3,674	612	73,797		73,797		73,797			11
12	Social Services	15,274		816	16,090		16,090		16,090			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,081,364	32,156	22,083	1,135,603		1,135,603		1,135,603			16
	C. General Administration											
17	Administrative	112,791		390,500	503,291		503,291	(354,379)	148,912			17
18	Directors Fees											18
19	Professional Services			47,065	47,065		47,065	5,795	52,860			19
20	Dues, Fees, Subscriptions & Promotions			23,983	23,983		23,983	(17,332)	6,651			20
21	Clerical & General Office Expenses	52,518	8,106	100,879	161,503		161,503	(64,141)	97,362			21
22	Employee Benefits & Payroll Taxes			289,162	289,162		289,162	(730)	288,432			22
23	Inservice Training & Education							50	50			23
24	Travel and Seminar			625	625		625	52	677			24
25	Other Admin. Staff Transportation			15,463	15,463		15,463	382	15,845			25
26	Insurance-Prop.Liab.Malpractice			96,045	96,045		96,045	1,502	97,547			26
27	Other (specify):*			56,034	56,034		56,034	(50,638)	5,396			27
28	**TOTAL General Administration**	165,309	8,106	1,019,756	1,193,171		1,193,171	(479,439)	713,732			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,572,646	226,462	1,145,621	2,944,729		2,944,729	(476,759)	2,467,970			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number WEST CHICAGO TERRACE #0022871 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			29,977	29,977		29,977	(5,233)	24,744			30
31	Amortization of Pre-Op. & Org.			2,494	2,494		2,494		2,494			31
32	Interest			37,143	37,143		37,143	592	37,735			32
33	Real Estate Taxes			65,016	65,016		65,016	745	65,761			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			23,669	23,669		23,669	2,684	26,353			35
36	Other (specify):* **RENT IME**			9,210	9,210		9,210	(9,210)				36
37	**TOTAL Ownership**			167,509	167,509		167,509	(10,422)	157,087			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			65,700	65,700		65,700		65,700			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,572,646	226,462	1,378,830	3,177,938		3,177,938	(487,181)	2,690,757			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(6,318)	30		9
10	Interest and Other Investment Income	(667)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(600)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(3,219)	21		18
19	Entertainment		20		19
20	Contributions	(16,936)	20		20
21	Owner or Key-Man Insurance	(730)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(56,034)	27		24
25	Fund Raising, Advertising and Promotional	(937)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(274)	20		28
29	Other-Attach Schedule	(2,744)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (88,459)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(398,722)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (398,722)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (487,181)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

WEST CHICAGO TERRACE

ID# 0022871

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 929	6	1
2	STAFF DEVELOPMENT	(3,673)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(2,744)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(600)	0	0	0	0	0	0	0	0	0	0	(600)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	268	0	0	0	0	0	0	0	268	5
6	Maintenance	929	0	1,538	464	0	0	0	0	0	0	0	2,931	6
7	Other (specify):*	0	0	81	0	0	0	0	0	0	0	0	81	7
8	**TOTAL General Services**	329	0	1,619	732	0	0	0	0	0	0	0	2,680	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(360,318)	5,939	0	0	0	0	0	0	0	0	(354,379)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	173	5,453	169	0	0	0	0	0	0	0	5,795	19
20	Fees, Subscriptions & Promotions	(18,147)	0	815	0	0	0	0	0	0	0	0	(17,332)	20
21	Clerical & General Office Expenses	(6,892)	5,448	(62,778)	81	0	0	0	0	0	0	0	(64,141)	21
22	Employee Benefits & Payroll Taxes	(730)	0	0	0	0	0	0	0	0	0	0	(730)	22
23	Inservice Training & Education	0	0	50	0	0	0	0	0	0	0	0	50	23
24	Travel and Seminar	0	0	52	0	0	0	0	0	0	0	0	52	24
25	Other Admin. Staff Transportation	0	302	80	0	0	0	0	0	0	0	0	382	25
26	Insurance-Prop.Liab.Malpractice	0	660	773	69	0	0	0	0	0	0	0	1,502	26
27	Other (specify):*	(56,034)	1,668	3,728	0	0	0	0	0	0	0	0	(50,638)	27
28	**TOTAL General Administration**	(81,803)	(352,067)	(45,888)	319	0	0	0	0	0	0	0	(479,439)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(81,474)	(352,067)	(44,269)	1,051	0	0	0	0	0	0	0	(476,759)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(6,318)	219	294	572	0	0	0	0	0	0	0	(5,233)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(667)	0	0	1,259	0	0	0	0	0	0	0	592	32
33	Real Estate Taxes	0	0	0	745	0	0	0	0	0	0	0	745	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	769	1,782	133	0	0	0	0	0	0	0	2,684	35
36	Other (specify):*	0	0	0	(9,210)	0	0	0	0	0	0	0	(9,210)	36
37	**TOTAL Ownership**	(6,985)	988	2,076	(6,501)	0	0	0	0	0	0	0	(10,422)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(88,459)	(351,079)	(42,193)	(5,450)	0	0	0	0	0	0	0	(487,181)	45

Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		EKS MANAGEMENT	LINCOLNWOOD	BOOKEEPING
				EMI ENTERPRISES	LINCOLNWOOD	MGMT CONSULT
				IME REALTY	LINCOLNWOOD	HOME OFFICE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 370,000	EMI ENTERPRISES, INC.		$	$ (370,000)	1
2	V								2
3	V								3
4	V	17	OFFICERS SALARY				9,682	9,682	4
5	V	19	ACCOUNTING FEES				173	173	5
6	V	21	OFFICE EXPENSE				5,448	5,448	6
7	V	25	TRANSPORTATION				302	302	7
8	V	26	INSURANCE				660	660	8
9	V	27	EMPLOYEE BENEFITS				1,668	1,668	9
10	V	30	DEPRECIATION				219	219	10
11	V	35	AUTO LEASE				769	769	11
12	V								12
13	V								13
14	Total			$ 370,000			$ 18,921	$ * (351,079)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	BOOKKEEPING FEES	$ 82,080	EKS MANAGEMENT, INC.		$	$ (82,080)	15
16	V								16
17	V								17
18	V	6	PAINTING / DECORATING				1,538	1,538	18
19	V	7	SCAVENGER				81	81	19
20	V	17	CFO SALARY				5,939	5,939	20
21	V	19	PROFESSIONAL FEES				5,453	5,453	21
22	V	20	WANT ADS/BACKROUND CHK				815	815	22
23	V	21	OFFICE EXPENSE				19,302	19,302	23
24	V	23	SEMINARS				50	50	24
25	V	24	IN-STATE LODGING/MEALS				52	52	25
26	V	25	TRANSPORTATION				80	80	26
27	V	26	INSURANCE				773	773	27
28	V	27	EMPLOYEE BENEFITS				3,728	3,728	28
29	V	30	DEPRECIATION				294	294	29
30	V	35	EQUIPMENT RENT				1,782	1,782	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 82,080			$ 39,887	$ * (42,193)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	36	OFFICE RENT	$ 9,210	IME REALTY CORP.		$	$ (9,210)	15
16	V								16
17	V								17
18	V	5	UTILITIES				268	268	18
19	V	6	REPAIRS & MAINTENANCE				464	464	19
20	V	19	PROFESSIONAL FEES				169	169	20
21	V	21	OFFICE EXPENSE				81	81	21
22	V	26	INSURANCE				69	69	22
23	V	30	DEPRECIATION				572	572	23
24	V	32	INTEREST				1,259	1,259	24
25	V	33	RE TAX				745	745	25
26	V	35	STORAGE FEES				133	133	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 9,210			$ 3,760	$ * (5,450)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	BERNARD COHEN	GENERAL PARTNE	ADMINISTRATION		SEE ATTACHED SCHEDULE			MGMT FEE	$ 20,500	17-3	1
2	MORRIS ESFORMES	GENERAL PARTNE	ADMINISTRATION					SALARY	9,682	17-7	2
3	AVRUM WEINFELD	CFO						SALARY	5,939	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 36,121		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EMI ENTERPRISES
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-1946
Fax Number: (847) 674-1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	OFFICER'S SALARY	PATIENT DAYS	797,100	13	$ 185,000	$ 185,000	41,708	$ 9,682	1
2	19	ACCOUNTING FEES	PATIENT DAYS	797,100	13	3,299		41,708	173	2
3	21	OFFICE EXPENSE	PATIENT DAYS	797,100	13	104,106	76,720	41,708	5,448	3
4	25	TRANSPORTATION	PATIENT DAYS	797,100	13	5,805		41,708	302	4
5	26	INSURANCE	PATIENT DAYS	797,100	13	12,620		41,708	660	5
6	27	EMPLOYEE BENEFITS	PATIENT DAYS	797,100	13	31,900		41,708	1,668	6
7	30	DEPRECIATION	PATIENT DAYS	797,100	13	4,180		41,708	219	7
8	35	AUTO LEASE	PATIENT DAYS	797,100	13	14,702		41,708	769	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 361,612	$ 261,720		$ 18,921	25

Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EKS MANAGEMENT
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-1946
Fax Number: (847) 674-1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	PAINTING / DECORATING	PATIENT DAYS	797,100	13	$ 29,397	$ 29,397	41,708	$ 1,538	1
2	7	SCAVENGER	PATIENT DAYS	797,100	13	1,544		41,708	81	2
3	17	CFO SALARY	PATIENT DAYS	797,100	13	113,499	113,499	41,708	5,939	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	797,100	13	104,205	93,812	41,708	5,453	4
5	20	WANT ADS/BACKROUND CHE	PATIENT DAYS	797,100	13	15,548		41,708	815	5
6	21	OFFICE EXPENSE	PATIENT DAYS	797,100	13	368,910	256,444	41,708	19,302	6
7	23	SEMINARS	PATIENT DAYS	797,100	13	940		41,708	50	7
8	24	IN-STATE LODGING/MEALS	PATIENT DAYS	797,100	13	994		41,708	52	8
9	25	TRANSPORTATION	PATIENT DAYS	797,100	13	1,506		41,708	80	9
10	26	INSURANCE	PATIENT DAYS	797,100	13	14,803		41,708	773	10
11	27	EMPLOYEE BENEFITS	PATIENT DAYS	797,100	13	71,229		41,708	3,728	11
12	30	DEPRECIATION	PATIENT DAYS	797,100	13	5,592		41,708	294	12
13	35	EQUIPMENT RENT	PATIENT DAYS	797,100	13	34,056		41,708	1,782	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 762,223	$ 493,152		$ 39,887	25

Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: IME REALTY CORP.
Street Address: 6865 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-1946
Fax Number: (847) 674-1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	RENTAL INCOME	268,762	13+FACIL	$ 7,839	$	9,210	$ 268	1
2	6	REPAIRS & MAINTENANCE	RENTAL INCOME	268,762	13+FACIL	13,572		9,210	464	2
3	19	PROFESSIONAL FEES	RENTAL INCOME	268,762	13+FACIL	4,925		9,210	169	3
4	21	OFFICE EXPENSE	RENTAL INCOME	268,762	13+FACIL	2,448		9,210	81	4
5	26	INSURANCE	RENTAL INCOME	268,762	13+FACIL	1,978		9,210	69	5
6	30	DEPRECIATION	RENTAL INCOME	268,762	13+FACIL	16,647		9,210	572	6
7	32	INTEREST	RENTAL INCOME	268,762	13+FACIL	36,747		9,210	1,259	7
8	33	RE TAX	RENTAL INCOME	268,762	13+FACIL	21,685		9,210	745	8
9	35	STORAGE FEES	RENTAL INCOME	268,762	13+FACIL	3,962		9,210	133	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 109,803	$		$ 3,760	25

Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	SOUTH TRUST		X	MORTGAGE		08/01/95	$ 1,390,000	$ 1,049,856	7/31/15		$ 37,143	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8	RELATED PARTY	X									1,259	8
9	TOTAL Facility Related						$ 1,390,000	$ 1,049,856			$ 38,402	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,390,000	$ 1,049,856			$ 38,402	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 62,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 63,216	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,216	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 63,800	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 65,016	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	60,461	8
	1998	61,858	9
	1999	60,602	10
	2000	61,406	11
	2001	63,216	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2001 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WEST CHICAGO TERRACE COUNTY DUPAGE

FACILITY IDPH LICENSE NUMBER 0022871

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-16-202-008	NURSING HOME	$ 63,216.36	$ 63,216.36
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 63,216.36	$ 63,216.36

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,898 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		1976	$ 100,000	1
2					2
3	TOTALS			$ 100,000	3

Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120		1976	1973	$ 1,233,000	$	25	$	$	$ 1,233,000	4
5											5
6											6
7											7
8	RELATED PARTY					572		572			8
	Improvement Type**										
9	BUILDING IMPROVEMENT			1983	34,112					34,112	9
10	BUILDING IMPROVEMENT			1987	17,555	557	20	557		8,427	10
11	BUILDING IMPROVEMENT			1988	51,503	1,635	31.5	1,635		24,457	11
12	BUILDING IMPROVEMENT			1990	4,140	131	31.5	131		1,599	12
13	BUILDING IMPROVEMENT			1992	23,333	741	31.5	741		7,613	13
14	BUILDING IMPROVEMENT			1993	22,204	610	31.5	610		5,855	14
15	BUILDING IMPROVEMENT			1994	74,985	1,923	39	1,923		16,896	15
16	TILE			1996	2,547	65	39	65		442	16
17	ROOFTOP COMPRESSOR			1998	1,653	42	39	42		187	17
18	FIRE BACKFLOW DEVICE			1998	7,245	186	39	186		752	18
19	DOORS			1999	2,734	70	39	70		266	19
20	SIGNS			1999	968	65	15	65		227	20
21	ELECTRICAL WORK			1999	8,138	209	39	209		758	21
22	CARPET, TILE, COVE BASE			2000	20,242	3,540	20	1,013	(2,527)	2,532	22
23	CUBICLE CURTAINS, DRAPES			2000	12,817	2,242	20	641	(1,601)	1,602	23
24	ROOF			2000	9,850	358	27.5	358		880	24
25	ASBESTOS ABATEMENT			2000	4,193	152	27.5	152		412	25
26	PAVING			2001	4,855	324	15	162	(162)	324	26
27	VINYL TILE			2001	4,165	1,020	20	208	(812)	416	27
28	FLOORING/CARPET			2002	8,200	2,747	20	410	(2,337)	410	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,548,439	$ 17,189		$ 9,750	$ (7,439)	$ 1,341,167	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 149,470	$ 13,360	$ 14,481	$ 1,121	10	$ 95,296	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	316,842					316,842	73
74	RELATED PARTY		513	513				74
75	TOTALS	$ 466,312	$ 13,873	$ 14,994	$ 1,121		$ 412,138	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,114,751	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 31,062	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 24,744	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (6,318)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,753,305	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: [ ] YES [ ] NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 13,155 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	MAINT.NURS,ACTIV	99 FORD VAN	$ 499.00	$ 6,086	17
18	NURSE, ACTIVITIES	99 ASTRO VAN	400.70	4,428	18
19					19
20					20
21	TOTAL		$ 899.70	$ 10,514	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care	N/A	visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 135,747	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 56,034)	812,710		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	68,224		6
7	Other Prepaid Expenses	29,978		7
8	Accounts Receivable (owners or related parties)	407,637		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,454,296	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	100,000		13
14	Buildings, at Historical Cost	1,233,000		14
15	Leasehold Improvements, at Historical Cost	315,439		15
16	Equipment, at Historical Cost	466,313		16
17	Accumulated Depreciation (book methods)	(1,803,025)		17
18	Deferred Charges	31,365		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 343,092	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,797,388	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 58,686	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	58,251		30
31	Accrued Taxes Payable (excluding real estate taxes)	21,317		31
32	Accrued Real Estate Taxes(Sch.IX-B)	63,800		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 202,054	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,049,856		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,049,856	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,251,910	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 545,478	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,797,388	$	48

***(See instructions.)**

Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 582,170	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 582,170	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	471,120	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(507,812)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (36,692)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 545,478	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,654,555	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,654,555	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	667	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 667	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,655,222	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	615,955	31
32	Health Care	1,135,603	32
33	General Administration	1,193,171	33
	B. Capital Expense		
34	Ownership	167,509	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	65,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,177,938	40
41	**Income before Income Taxes (line 30 minus line 40)****	477,284	41
42	**Income Taxes**	(6,164)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 471,120	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	607	607	$ 15,462	$ 25.47	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,669	5,632	120,449	21.39	3
4	Licensed Practical Nurses	9,924	10,622	197,673	18.61	4
5	Nurse Aides & Orderlies	47,121	50,884	505,368	9.93	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,056	2,129	22,611	10.62	8
9	Activity Director					9
10	Activity Assistants	8,401	8,593	69,511	8.09	10
11	Social Service Workers	1,224	1,388	15,274	11.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,860	15,826	139,597	8.82	15
16	Dishwashers					16
17	Maintenance Workers	3,052	3,862	53,853	13.94	17
18	Housekeepers	13,291	14,213	99,846	7.02	18
19	Laundry	4,329	4,766	32,677	6.86	19
20	Administrator	3,476	3,667	112,791	30.76	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,083	5,349	52,518	9.82	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,176	2,080	12,000	5.77	31
32	Other Health Care(specify)					32
33	Other(specify) SEE ATTACHED	9,899	10,360	123,016	11.87	33
34	TOTAL (lines 1 - 33)	131,168	139,978	$ 1,572,646 *	$ 11.23	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 5,940	1-3	35
36	Medical Director	O	0	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	10,612	10-3	39
40	Physical Therapy Consultant	L	2,569	10a-3	40
41	Occupational Therapy Consultant	Y	4,174	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	612	11-3	44
45	Social Service Consultant	E	816	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 24,723		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ZACHERY CAULKINS	ADMIN	0	$ 112,791
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 112,791

B. Administrative - Other

Description	Amount
EMI ENTERPRISE	$ 370,000
BERNARD COHEN	20,500
TOTAL (agree to Schedule V, line 17, col. 3)	$ 390,500
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
NCS	DATA PROCESSING	$ 5,458
ALPHA DATA	DATA PROCESSING	3,249
MAXXSOURCE	DATA PROCESSING	1,500
LTC SOLUTIONS	DATA PROCESSING	1,320
LAWRENCE SCHWARTZ	LEGAL	9,000
KRUPNICK, BOKOR	ACCOUNTING	16,400
PROFESSIONAL ASSOC.	PROPERTY SURVEY FEE	3,200
EMI ENTERPRISES	ASSESSMENT FEE	3,084
LINCOLNWOOD FUNDING	REMARKETING FEE	3,434
PERSONNEL PLANNERS	UC CONSULTANT	420
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 47,065

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 54,361
Unemployment Compensation Insurance	10,759
FICA Taxes	120,309
Employee Health Insurance	102,503
Employee Meals	#REF!
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	500
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	730
INSURANCE - EXECUTIVE LIFE VI 21	(730)
TOTAL (agree to Schedule V, line 22, col.8)	$ #REF!

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	892
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	1,211
TRUST/FRANCHISE/CONTRIB/ETC	16,936
LICENSES & PERMITS	1,425
DUES & SUBSCRIPTIONS	3,319
MGMT CO ALLOCATION	815
TRUST/FRANCHISE/CONTRIB/ETC	(16,936)
Less: Public Relations Expense	(0)
Non-allowable advertising	(937)
Yellow page advertising	(274)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,651

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
RELATED PARTY	52
Seminar Expense	
	625
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 677

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WEST CHICAGO TERRACE # 0022871 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	PAINTING/DECORATIN	2000	$ 2,787	3	$	$ 464	$ 929	$ 929	$ 465	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 2,787		$	$ 464	$ 929	$ 929	$ 465	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $ 3888**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,563** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **65,700**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **#REF!** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: WEST CHICAGO TERRACE **#0022871** **Report Period Beginning: 01/01/2002** **Ending: 12/31/2002**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	5,940	
	REPAIRS & MAINTENANCE		0	
			0	5,940
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		23,778	
	ELECTRICITY		27,282	
	WATER		3,583	
	CABLE TV - LOBBY		1,416	
			0	56,059
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		5,247	
	PAINTING & DECORATING		294	
	BUILDING REPAIRS		8,632	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		8,558	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		3,619	
	EXTERMINATING SERVICE		2,915	
	FIRE SERVICE		5,885	
			0	
			0	
			0	35,150
7	**OTHER**			
	SCAVENGER		5,762	
	SECURITY SERVICE		871	6,633
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	0	0

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	10,612	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL CONSULTANT		550	
	DENTAL SERVICES		2,750	13,912
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	2,569	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	4,174	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	6,743
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	612	
			0	612
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	816	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	816
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number WEST CHICAGO TERRACE **#0022871** **Report Period Beginning: 01/01/2002** **Ending: 12/31/2002**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	390,500	390,500
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	11,526	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	35,539	
			0	47,065
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	937	
	EMPLOYEE WANT ADS	XIX F	892	
	CONTRIBUTIONS	VI 20 XIX F	150	
	DUES & SUBSCRIPTIONS	XIX F	3,319	
	LICENSES & PERMITS	XIX F	1,625	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	274	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	16,786	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	23,983
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES		130	
	EQUIPMENT REPAIR & MAINTENANCE		600	
	OUTSIDE CLERICAL SERVICES		82,080	
	PENALTIES / OVERDRAFT CHARGES	VI 18	3,219	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		11,177	
	MESSENGER SERVICE		0	
	STAFF DEVELOPMENT		3,673	100,879

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	120,309	
	UNEMPLOYMENT COMPENSATION	XIX D	10,759	
	WORKERS COMPENSATION INSURANC	XIX D	54,361	
	HOSPITALIZATION INSURANCE	XIX D	102,503	
	EMPLOYEE BENEFITS - OTHER	XIX D	500	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	730	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	289,162
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	625	
	TRAVEL	XIX G	0	
			0	
			0	625
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		15,463	15,463
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		96,045	96,045
27	**OTHER**			
	BAD DEBTS	VI 24	56,034	
			0	56,034

GRAND TOTAL COLUMN 3 OTHER 1,145,621